# GP CONTRACT UPDATE AND CLUSTER APPROACH

## Aim

1.1 This paper aims to provide the Scottish Borders Integrated Joint Board with an update on the Transitional Quality Arrangements (TQA) for the new General Medical Services (GMS) Contract 2016/17 and the progress in relation to the development of local GP cluster arrangements.

1.2 Following receipt of a Scottish Government Circular on 26th February 2016 work is underway locally to support the implementation of its stated recommendations.

1.3 The GP contract arrangements are agreed by the Health Board. This paper is intended to give some background to the Integration Joint Board particularly in relation to the link with the Health & Social Care localities.

## Background

2.1 Changes to the way in which general practice contributes to patient outcomes as expressed in the current GMS Contract arrangements are being implemented. At their heart it means moving away from the bureaucratic "top down" approach of the previous Quality Outcomes Framework (QOF) and relying more fully on the professionalism of GPs and maximising the benefits from promoting that professionalism in a structured collaborative context.

2.2 This is to be a "peer-led, values driven" approach.

2.3 Between now and April 2017 the introduction of a comprehensive national approach to GP "cluster working" will take place. Clusters are to be small groups of practices – perhaps up to 6-8 practices – agreeing with relevant local partners a clear set of outcomes and a means to review those outcomes collaboratively; improving outcomes through further cycles with those same outcomes, or moving on to other outcomes across the patient pathway in a repeating pattern. This is to be underpinned by an evidence based approach to improvement, including clear measures of success and promoting a more deeply collaborative way of working with others in the local health and social care system.

2.4 This principle, of practices working more closely together to the benefit of patients, practices and the wider health and social care system, is also reflected in the Localities Guidance issued to support health and social care integration.

2.5 This is not a change that will happen overnight. Iit's a journey not an event. However, by the Scottish Government removing QOF from April 2016 this is felt to be a very positive start.

2.6 By April 2017 the new model of Cluster working is to be be established. Through this transitional year practices need to align themselves into clusters, establish a practice quality lead (PQL) and then in liaison with the Local Medical Committee (LMC), the Integrated Joint Board (IJB) and the NHS Board, are to choose and appoint a Cluster Quality Lead (CQL).

2.7 The role of the Cluster Quality Lead (CQL) has been deliberately left as a "non – prescriptive" role in order to allow local regions to develop a system of engagement which best suits their needs.

2.8 The February circular describes a four stage approach to the implementation of the TQA for 2016/17.

**Stage 1** – first quarter of 2016/17 (1.4.16 to 30.6.16)
Practices agree who will fulfil the Practice Quality Lead (PQL) role and that person will work with the local partnership liaison person and LMC representatives to agree the cluster arrangements i.e. which practices are in which cluster.

The practices will also start to consider the issues outlined in Annex A of the circular, with a view to agreeing what actions arising from them, or other agreed cluster alternatives, will be taken forward in stage/quarter 4. These were described as the following:

1. Registers, coding and lifestyle advice
2. Flu immunisations
3. Quality, safety and prescribing
   - Access – review last 2 PAAR reports; the practice must have access to a cluster access report
   - Complex patients and anticipatory care plans – ACP's for those considered to benefit most, review existing ones as appropriate; assessment of quality using a template (latter not yet agreed)
   - Quality prescribing – continue to work with prescribing advisors, support pharmacists etc. to decide appropriate actions for the practice.

**Stage 2** – second quarter (1.7.16 to 30.9.16)
PQLs and the partnership/board and LMC, identify, appoint and empower a Cluster Quality Lead and agree the time commitment to which this role will need to be resourced and how it will operate locally. ***The CQL role will be resourced by the partnership/board.***

**Stage 3** – third quarter (1.10.16 to 31.12.16)
The PQLs and CQLs begin to build relationships locally via the clusters, between and across practices, primary and secondary care, health and social care and between the public and third/voluntary sectors.

Practices and the local system start to consider the issues arising from the activities outlined in Annex A of the circular, and any the other issues that might be local priorities, and agree by the end of this quarter which to take action on in quarter 4.

**Stage 4** – fourth quarter (1.1.17 to 31.3.17)
Practices and the local system take action on the priorities agreed at the end of quarter 3 and agree evaluation/outcome measures that will demonstrate quality improvement.

**2.9 Current Position**

As required, practices have been identifying their Practice Quality Leads and to date all bar 4 practices have completed this requirement. Early discussions are now taking place to identify the role and remit of the Cluster Quality Leads and to agree how they will integrate in to the wider partnership arrangements.

2.10 With regards to cluster developments and with reference to the agreed locality boundaries in Scottish Borders, the LMC has agreed with practices the creation of 4 GP Clusters. The proposed structure seeks to makes each cluster an appropriate functional size to be able to both effect change and manage themselves cohesively. The detailed workings of this proposal are attached in embedded as an attachment in **appendix 1.**

2.11 The proposed GP clusters for the Borders are:
**West Cluster** incorporating the following practices: West Linton, Neidpath (Peebles) Tweed (Peebles) and Innerleithen with a population of 17,814.

**South Cluster** incorporating the following practices: Selkirk, Teviot (Hawick), O'Connell Street (Hawick) and West Linton with a population of 26,568.

**Central Cluster** incorporating the following practices: Roxburgh Street, Waverley, Glenfield, Ellwyn, Braeside (all Galashiels), Eildon (Melrose / Newtown St Boswells), Earlston and Stow & Lauder with a population of 31,778.

**East Cluster** incorporates the following practices: Eyemouth, Duns, Merse (Duns), Coldstream, Greenlaw, Kelso and Jedburgh with a population of 38,775.

2.12 The Borders LMC has highlighted a range of concerns and risks, as agreed by the Scottish School of Primary Care, around the Transitional Quality Arrangements and summarised that the principal risks through this process relate to drift due to the loss of the previous QOF arrangements and a subsequent lack of focus on the potential of the clusters. A lack of capacity in primary care to support local developments and to meet all expectations, and as a consequence disengagement by the key stakeholders involved is also a risk.

2.13 A key message for the SSPC was that if the CQL role is not quickly developed, there is a risk of new operating arrangements within health and social care partnerships moving forward without robust GP involvement, negatively impacting on the essential engagement of general practice with the rest of the NHS and Health and Social Care Partnerships.

2.14 Therefore the establishment of CQLs is the critical next step in this process to ensure continued engagement with all appropriate stakeholders

2.15 The Scottish General Practice Committee define this role as: *A GP nominated by the cluster with responsibility and protected time to provide a Continuous Quality Improvement leadership role in the GP cluster. The role will liaise between practices and the NHS Board/Health and Social Care Partnership on quality improvement issues.*

2.16 A challenge for us locally and reflected nationally, is defining this role in a way that ensures optimal recruitment as well as ensuring the appropriate level of resource is available in terms of funding and support to allow them to function effectively.

2.17 In essence, therefore, we now need to focus and agree on three main actions:

1. **Remit of CQLs** - the LMC would offer a view that they are to engage with the GP Cluster on areas of clinical and organisational quality whilst liaising between those practices and the HB / IJB. They will agree outcome measures that will show quality improvement and collate data related to suggested quality areas of focus e.g. complex patients and anticipatory care planning, or quality prescribing.

2. **Capacity of CQLs** – the current allocation of 2 hours a month for the Practice Quality Lead this year may need review. The CQL will need to be able to engage with all practices in their cluster. This will require time for practice to practice liaison and engagement, as well as additional time for meeting with the other cluster leads as well as other key governance structures e.g. GP Sub Committee, LMC, Locality Planning arrangements.

   The LMC therefore are proposing that the CQL role is likely to need **at least 2 sessions a week** for each of the four GP Clusters in the first instance to make the new arrangements viable.

   As discussed at a previous Integrated Joint Board one of the most challenging aspects of this position and development will be being able to find appropriate cover to allow the CQLs to fulfil their function effectively.

3. **Recruitment process for CQLs** - The LMC has articulated a strong view on this matter and feels the individuals selected are required to have a certain stature / gravitas to be able to perform across practice clusters in an effective manner. They are very keen to be actively involved in the appointment process.

**Summary**

3.1 Good progress has been made locally in response to the Transitional Quality Arrangements for the new General Medical Services (GMS) Contract 2016/17 and we are broadly on track in relation to the 4 stage approach described.

3.2 Further work and support is required to maintain the impetus needed to fully meet the timescales set out in the TQA and specifically, agreement between the LMC and partnership organisational structures with regards to the role of the Cluster Quality Lead, the recruitment process, and any associated resource, requires to be finalised.

3.3 Formal arrangements in support of the delivery of the new contract will be negotiated and agreed by NHS Borders. The links at a locality level between the GP practices and partners through the cluster approach allows the opportunity for real engagement that will facilitate the planning and delivery of outcomes that will be jointly owned. In addition, there is an opportunity to synchronise quality and service improvement through the cluster leads within the context of the Strategic Plan with a collective drive towards the delivery of the national outcomes. The IJB will be updated on progress.

**Recommendation**

The Health & Social Care Integration Joint Board is asked to **note and consider** the report.

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| **Policy/Strategy Implications** | Compliance with the new GP contract arrangements for NHS Borders. |
| **Consultation** | With the formal and informal GP networks |
| **Risk Assessment** | Will be carried out by NHS Borders as the new contractual arrangements are agreed. |
| **Compliance with requirements on Equality and Diversity** | Applicable in the context of the IJB equalities compliance in relation to the Strategic Plan. |
| **Resource/Staffing Implications** | To be clarified by NHS Borders. |

**Approved by**

| Name | Designation | Name | Designation |
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